Miami-Dade County Ryan White Title I Program
Performance Improvement Plan

I. Purpose

The 2000 reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act requires grantees to establish a quality management program "to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services." The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services is the federal granting agency for the CARE Act. HRSA mandates that Ryan White CARE Act grantees, as well as all service providers, must measure and influence quality of care and patient improvements in order to support continued funding by the Congress.

This performance improvement plan is designed to meet those criteria, and to establish a systematic approach to quality assessment and performance improvement for the Miami-Dade County Ryan White Title I Program.

The plan addresses key CARE Act themes, which are addressed directly in the Miami-Dade HIV/AIDS Partnership Comprehensive Plan:

- Improved access to and retention in care for HIV positive individuals
- Quality of services and related outcomes
- Linkage of social support services to medical services
- Elimination of disparities in care.

This Performance Improvement Plan establishes the methods for maintaining quality in the implementation of the activities in the Comprehensive Plan.

The underlying principles of this Performance Improvement Plan are:

- All providers must involve themselves and participate in the process of developing and implementing performance improvement activities in their areas of expertise.

- Small, systematic, measurable steps can lead to major change.

- The Performance Improvement Advisory Team (PIAT) will serve as a core advisory group reviewing and recommending quality improvement initiatives to the Title I program.

- Education about and adherence to best practices leads to improved service provision and improved quality of service.

II. The Performance Improvement Program

A. *Mission*

The Miami-Dade County Ryan White Title I program is developing a system-wide and agency level quality assessment, management and improvement program, known as the Performance Improvement Program. Its mission is to:

- Assure equitable access to high-quality care
- Improve clinical outcomes
- Maximize collaboration of stakeholders and coordination of services
- Ensure high quality customer service
- Ensure compliance with HRSA mandates.

B. *Method*

The methodology to be used by the Performance Improvement Program includes a planning process as well as a cycle of assessment, analysis and improvement, including recognition and corrective action. This process is undergirded by continuing education and training. See Figure 1.

The planning phase involves the development of specific standards of care, outcome measures for services, and coordination of efforts and communication between providers, the Miami-Dade County HIV/AIDS Partnership, Miami-Dade County Office of Strategic Business Management (OSBM) and the Performance Improvement staff (Williams, Stern & Associates). A key element of the program is ongoing education, providing both targeted technical assistance to providers and general training on standards of care, performance excellence, and quality enhancement principles and techniques.

The assessment phase of the Performance Improvement Program includes a coordinated system of ongoing record reviews of programmatic and administrative functions. Internal provider review systems will be supplemented by external review by Williams, Stern & Associates and the Miami-Dade County Office of Strategic Business Management. Other assessment activities include gathering SDIS data, conducting surveys of consumer, provider and participant satisfaction, site visits, and focus groups.
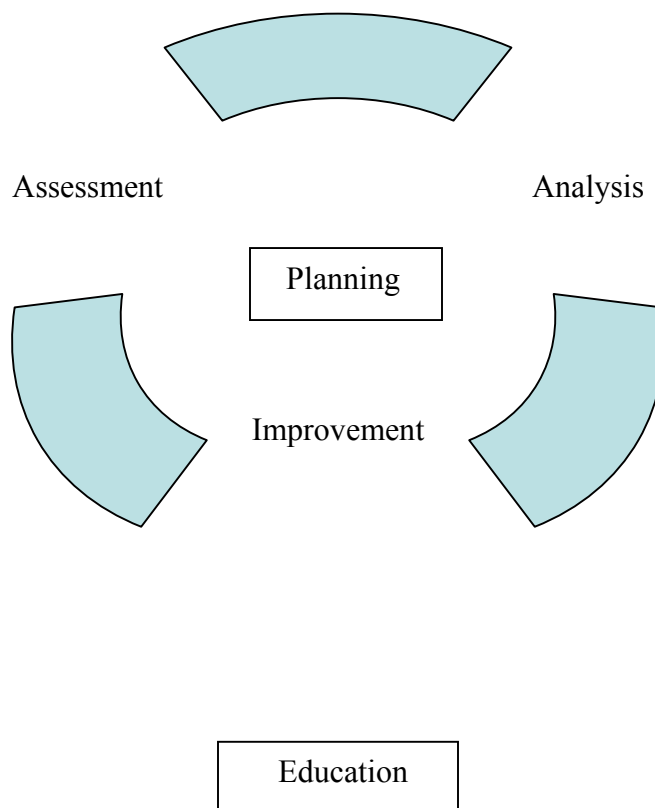
Information from the assessment phase then undergoes analysis, done collaboratively by providers, Miami-Dade County Office of Strategic Business Management and the Performance Improvement staff from Williams, Stern & Associates. This analysis compares results of the record reviews, data collected, survey results and other information to the goals established in the Comprehensive Plan, by the Miami-Dade HIV/AIDS Partnership or the Miami-Dade County Office of Strategic Business Management. Status of progress toward goals is monitored by the OSBM, the Performance Improvement staff, and the Performance Improvement Advisory Team in collaboration with the Planning and Implementation Committee of the Partnership.

When analysis reveals that performance is not meeting established goals, improvements may be made through the use of improvement teams (specific cross-functional work groups developed to address needed improvements) and existing committees using the Plan-Do-Study-Act (PDSA) model and an array of process improvement and performance tools. Success in implementing improvements and/or meeting established goals will be recognized by the Office of Strategic Business Management, in collaboration with the Partnership. Annually, providers excelling in the areas of client satisfaction, overall performance, and most improved performance will be considered to receive public recognition. The Performance Improvement Advisory Team, in consultation with OSBM, will develop guidelines for this recognition.

Specific performance improvement plans may be requested from providers to address issues identified by reviews and evaluation of data. The Performance Improvement Program staff and Office of Strategic Business Management will provide technical assistance and support as needed to assist organizations with this process. There may also be a need for corrective action steps and sanctions against providers who consistently fail to improve performance. The Office of Strategic Business Management, as the sole contractual authority, would establish measures for corrective action if needed.

The continuous Assessment, Analysis and Improvement cycle, informed by and supported by Education, is pictured in Figure 1, below:

Assessment   Analysis

Planning

Improvement

Education

The Performance Improvement Plan includes various activities, e.g. record reviews (internal and external), training (customer service, measuring performance, use of data, and how to measure performance), and the implementation of improvement teams for priority projects. The ongoing planning process will define roles and activities within the various components. Major components and activities will remain constant, though their focus will change as the plan cycles through phases and time frames. Because quality improvement is a continuous process, so too, the plan will continuously change and evolve within its own framework. The Performance Improvement Plan will be formally reviewed annually, as a part of the review of the Comprehensive Plan.

C. *Participants/Stakeholders*

Service Providers

The provider network for Ryan White Title I services includes more than thirty contracted providers offering medical and support services. These services include outpatient medical care, dental care, substance abuse treatment (residential and outpatient), psychosocial counseling, home health care, prescription drugs, case management and peer counseling, outreach services, food services, transportation services, utilities assistance, day care, health insurance and legal services.

<u>All Title I service providers are required to have in place a process to assess the quality of care and service provided.</u> Surveys of provider programs have revealed great variation in understanding and ability to perform internal reviews and performance improvement activities. Agencies offering services to the Ryan White Title I community range from JCAHO accredited hospitals to emerging Community Based Organizations. A major goal of the Performance Improvement Program is to reduce or eliminate disparities in care and service, no matter where or by what agency the service is provided. Thus, an important activity of the program will be to assist providers where needed in the form of training and technical assistance at the agency level.

<u>Individual providers' Performance Improvement plans are expected to include the following internal functions:</u>

- Self assessment of performance, including random as well as focused record reviews and measuring customer satisfaction

- Problem identification and problem-solving activity using a standard model

- Implement and evaluate changes

The recommended method for accomplishing these improvements is Plan, Do, Study, Act. The goal is to develop and routinize a process for continually identifying opportunities to improve, and acting on the opportunities.

The Performance Improvement Program is also designed, at the system level, to involve all contracted providers as participants and partners. Both the internal quality improvement efforts at the agency level and the external system-wide reviews and improvements will be provided to and reviewed by the Miami-Dade County Office of Strategic Business Management and the Performance Improvement Advisory Team. Williams, Stern & Associates and the team will assist in identifying important aspects of care and treatment to be measured and reported for each service category. These measures will include both processes and outcomes.

Miami-Dade County Office of Strategic Business Management

Title I funds flow from the federal government to Miami-Dade County. Day-to-day activities of the program are administered by the Miami-Dade County Office of Strategic Business Management. All contracts are approved by the Mayor and the Miami-Dade County Board of County Commissioners. As the administrative agent for the Ryan White Title I program, the Miami-Dade County Office of Strategic Business Management is responsible for:

- Issuing Requests For Proposals
- Negotiating and executing contracts and amendments
- Providing information on program requirements to contracted providers
- Monitoring contract compliance
- Management and oversight of the Performance Improvement Program
- Auditing submitted bills to ensure compliance with service/billing requirements
- Authorizing payments
- Implementation of recommendations from the Performance Improvement Program
- Quality management and performance improvement consulting with the Miami-Dade HIV/AIDS Partnership
- Complying with federal reporting requirements
- Submitting the Ryan White Title I application for funding to the federal government.
- Participating in and overseeing the activities of the Miami-Dade HIV/AIDS Partnership.

The Ryan White CARE Act states that responsibility for implementation of a quality management program rests with the grantee, i.e. Miami-Dade County as represented by the Office of Strategic Business Management.

Performance Improvement Staff

Williams, Stern & Associates, under contract with Miami-Dade County Office of Strategic Business Management, coordinates and implements the Performance Improvement Plan and Program (Quality Management Program), provides staff support to the Miami-Dade HIV/AIDS Partnership, conducts needs assessments and data analyses, assists in preparation of the federal grant application, and provides training for providers. The Performance Improvement staff is responsible for development of the plan, training on quality improvement for providers, conducting record reviews, writing record review reports, providing technical assistance as appropriate, establishing goals for improvement and outcome measures based on process indicators, developing ongoing processes for improvement/change in performance improvement

activities and modifying the plan as needed in collaboration with the Miami-Dade County Office of Strategic Business Management and the Performance Improvement Advisory Team. Williams, Stern & Associates will present reports and information to the team and Miami-Dade County Office of Strategic Business Management along with advice for needed action and change as the Performance Improvement Program develops. Williams, Stern & Associates will also report on quality and improvement activities to the Miami-Dade HIV/AIDS Partnership and its committees.

Performance Improvement Advisory Team

The Performance Improvement Advisory Team (PIAT) is comprised of providers and consumers acting in an advisory capacity to both Williams, Stern & Associates and the Miami-Dade County Office of Strategic Business Management. Each service category should be represented on the PIAT. Performance Improvement Advisory Team membership will include a representative of each of the top priority service categories (Outpatient Medical Care, Prescription Drugs, Case Management, Substance Abuse Residential Treatment, and Dental Care). Other service categories will be included on the team as needed for addressing particular quality initiatives. Participation of PLWH/As and Ryan White Title I service recipients will be included through the PIAT's collaboration with the providers' Patient Advisory Committees. Performance improvement information will be shared with consumers through the patient advisory committees, and input, suggestions and review of performance improvement initiatives will be gathered from consumers through these committees. The team will function as a conduit to and from the provider community as well as the community of consumers. As such, it should communicate with all providers to obtain feedback on the quality improvement process. Input and guidance from providers and consumers of services, via this advisory team, is used in establishing standards, outcomes and other measures. The knowledge of the service delivery system and agency workings that providers and service recipients bring to the process is indispensable in creating an effective Performance Improvement Program.

Membership on the Performance Improvement Advisory Team is voluntary. Through rotating participation, the goal is to have all Title I service categories represented and participating on the team at some point in time. The team meets monthly.

The team will participate in developing quality initiatives and reviewing results of reviews. The PIAT and staff will develop key indicators for service categories to become part of system-wide monitoring and agencies' internal monitoring. Finally, the team will review results and recommend solutions, interventions, and improvement actions. The PIAT does not set policy, provide accreditation, or rate providers, and is not a committee of the Miami-Dade HIV/AIDS Partnership. The Performance Improvement Advisory Team functions in a strictly advisory capacity.

Outline of Performance Improvement Plan Core Processes

    I.   **Determine outcome and performance measures**

    II.   **Implement outcomes**

    III.   **Collect data**

    IV.   **Review & analyze data**

    V.   **Develop & review benchmarks and targets based on baseline data**

    VI.   **Identify & recognize providers with reported improvements in customer satisfaction, overall performance and most improved performance**

    VII.   **Identify opportunities for improvement and develop improvement action plans**

    VIII.   **Evaluation**

    IX.   **Enforcement of standards**

Performance Improvement Plan Action Plan

PROCESS	ACTIVITY	FREQUENCY	RESPONSIBILITY	RESOURCES
1. *Determine outcome and performance measures*		Develop initially, review and revise annually	PI staff for OSBM	Care & Treatment Committee, Performance Improvement Advisory Team, Medical Care Subcommittee, HRSA TA Manual, comparative information
2. *Implement outcomes*				
	2a. Communicate outcomes to providers	Initially, and annually	OSBM, PI staff	PIAT
	2b. Train providers on outcomes and measurements	Initially and annually	OSBM, PI staff	PIAT
	2c. Formalize outcome measures into policies, guidelines and standards	Initially	OSBM, PI staff	PIAT
	2d. Technical Assistance for outcomes and provider performance improvement plans	Initially and as needed	OSBM, PI staff	PIAT
3. *Collect data*				
	3a. Programmatic record reviews for outpatient medical care	Biannually, more often if needed	Providers internal review; PI staff external review, OSBM	PI staff, AETC, contractors

PROCESS	ACTIVITY	FREQUENCY	RESPONSIBILITY	RESOURCES
3. Collect data (continued)				
	3b. Programmatic record reviews for targeted services as identified needs emerge	As needed	Providers internal review; PI staff external review, OSBM	PI staff, AETC, contractors
	3c. Entry of client information and service utilization data onto the SDIS	Ongoing collection	Providers	ACMS PI staff
	3d. Consumer satisfaction surveys	Biannually external Annually internal	PI staff Providers	Providers PI staff
	3e. Provider satisfaction surveys	Annually Biannually	Providers PI staff	Performance Improvement Advisory Team
	3 f. Quarterly report from providers to Title I grantee (OSBM) indicating progress on key indicators of outcomes	Quarterly	Providers, OSBM	Grantee, PI staff
	3g. Complaint and grievance records	Annual	Providers	Performance Improvement Advisory Team, PI staff
	3h. Comparative data	Annual	PI staff	Performance Improvement Advisory Team
	3i. Billing record review	Biannual	OSBM	Performance Improvement Advisory Team, PI staff
	3j. Attendance at training activities	Tracked continuously	PI staff	PIAT, OSBM

PROCESS	ACTIVITY	FREQUENCY	RESPONSIBILITY	RESOURCES
4. Review and analyze data		Annual	PI staff	Performance Improvement Advisory Team, all data sources, providers
	4a. Reporting of results from reviews and surveys, to providers and OSBM	Following each review or survey	PI staff	PIAT
	4b. Recommendations for improvement, resulting from reviews and surveys	Following each review or survey	PIAT, PI staff	OSBM
	4c. Review and analysis of other data collected		PIAT, OSBM, PI staff	
5. Develop and review benchmarks and targets, based on baseline data.		Annual	PI staff	Comprehensive Plan, Outcome measures' results, Performance Improvement Advisory Team
6. Identify and publicly recognize organizations showing improvements in client satisfaction, best overall performance, and most improved performance		Annual	OSBM, PI staff	Performance Improvement Advisory Team
7. Identification of Opportunities for Improvement and development of action plans to address them				
	7a. Identify priorities for improvement	Annual	PI staff, PIAT, providers	Performance Improvement Advisory Team, OSBM, Planning & Implementation Committee

PROCESS	ACTIVITY	FREQUENCY	RESPONSIBILITY	RESOURCES
7. Identification of Opportunities for Improvement and development of action plans to address them (continued)				
	7b. Choose improvement projects	Annual	Recommendations from PIAT, OSBM, Planning & Implementation committee, PI staff, Providers	All data collected and results of data analysis, results of planning process,
	7c. Provide training and technical assistance to providers on Opportunity for Improvement (OFI) action plans, improvement projects, improvement teams and PDSA	Ongoing	OSBM, PI staff, PIAT, consultants	
	7d. Recruit, train, and convene Improvement Teams (to address improvement projects)	One or more annually for Title I Program; one annually for each provider internally	PI staff	Performance Improvement Advisory Team
	7e. Improvement teams use PDSA model to study assigned issue, develop, test and implement improvements	Same as above	Providers, PI staff, OSBM	Performance Improvement Advisory Team
	7f. Re-measure indicators used by Improvement Teams	After implementation of improvement	Improvement teams and providers internally; PI staff	Performance Improvement Advisory Team,

			and OSBM externally	
8. Evaluation				
	8a. Review and analysis of results of improvement projects	After implementation of improvement	Providers internally; PI staff and OSBM externally	Performance Improvement Advisory Team
	8b. Standardize and communicate improvements	After improvement projects	Improvement teams and providers internally; PI staff and OSBM externally	Performance Improvement Advisory Team, PI staff
	8c. Identify areas that did not improve as planned or that need further improvement	After improvement projects	Providers internally; PI staff and OSBM externally	Partnership Committees
9. Enforcement of standards				
	9a. Review and analysis of performance data and improvement project data	Following improvement projects	PI staff, providers, PIAT, OSBM	Partnership committees
	9b. Determine and implement policy or contract changes as needed	Following review of data	OSBM	PIAT, PI staff, providers, Partnership

Attachment 1. What is Quality?

Quality is defined as services that meet or exceed guidelines, standards and customer expectations.

Quality service includes customer service, as defined by the customer. This may include such elements as courtesy, timeliness, and responsiveness,   Quality service also includes accurate assessment of needs, referral to needed services, assistance in getting those services when necessary, follow-up and documentation of all of this. Quality assurance includes checking documentation for completeness and accuracy, making sure things got done that needed doing, and checking with the client on results. Quality improvement is the activity of using the information gathered in quality assurance activities and using it to change and improve operations, services, or other elements of care in a systematic manner.

How can we ensure quality services?

In order to ensure that services meet or exceed established guidelines, standards and customer expectations, we must:
- Understand those criteria
- Know where we stand in regard to the criteria and expectations (based in data collection)
- Determine in what ways services are not meeting the criteria
- Plan improvements in services, making our decisions based on data, not hunches, intuition or even experience. Seek and analyze root causes of problems. Seek permanent, systematic and systemic solutions rather than "quick fixes".
- Test the improvements, measure the results.
- Implement improvements, moving toward exceeding the guidelines, standards and expectations.

Data: Information for Improvement

Three categories of information are used to measure quality:

- Structure (e.g., staff, policies and procedures, facilities…systems)
- Process (e.g., assessment, care planning, monitoring adherence…activities)
- Outcomes (e.g., change in the patient, change in cost or utilization…results).

Data and measurement are the essential tools of quality improvement. Without the ability to obtain and use data and count events, it is impossible to measure, evaluate and improve services.

Once data is collected it must be analyzed in a routine way. There are many tools for measuring these, and most can be produced in graphic form. We can measure trends and changes over time, and displaying them graphically aids in understanding where we are going. Numbers are sometimes difficult to view but they are essential in performance improvement. Tools for evaluating data and deciding what needs to be improved are necessary to the quality management program. All participants will learn how to display and use data, develop improvement teams

and use the Plan-Do-Study-Act model and various techniques to formally identify causes and implement improvements.

Results of performance must be shared within the organization. Openness is a hallmark of the quality improvement program and process. Data must be routinely analyzed so progress can be measured. If expectations are not met, priorities for improvement will be identified and referred to a cross-functional Improvement Team. Improvement Teams addressing system-wide improvements will include representatives of various providers and services, as well as PLWHAs. Improvement Teams working with issues within a specific organization will consist of members of that organization including management and front-line staff. These teams will:

- Analyze the process leading to the outcomes
- Identify the root causes of the problem
- Identify changes needed
- Make the changes in the process
- Test the changes and measure results
- Implement the change.
- Measure the gain

It is important to have open minds and not assume the answer is clear. The quality experts advise to ask "why?" five times to get at the real (root) causes. Involvement of more than one person is very helpful in this process. Process analysis tools the group can use include:

- Brainstorming
- Process flow analysis and charting
- Focused record review
- Look at more data
- Ask the recipient of the services
- Consider comparative data

A formal process is important, and including people with different perspectives is important. Finding causes and improving processes is the key to improving outcomes. Blame placing is not a part of this system. The focus is upon continuous improvement and teamwork.

Attachment 2. Outcomes

Development of Outcome Measures

Outcomes are results, positive or negative. In health care, an outcome is a precise quantification (measure) of a change in a patient's health status between two or more time points. It can also be an event that represents a surrogate for change in health status, such as a return to full time work. Outcome measures can include:

- Health status
- Quality of life
- Cost of care
- Patient satisfaction

Outcomes are the ultimate measure of quality, as they focus on the client. Outcomes also focus on a result, an end-point: for example, did the patient live, or did the patient get better, or did health status deteriorate? However, structure and process must also be examined in order to find out where things went wrong, to identify where improvements are needed and to discover best practices, learn from role models, and share improvements and effective methods.

Williams, Stern & Associates, working in conjunction with the grantee and the other members of the Performance Improvement Advisory Team, is developing client-level and system-level outcome measures. Information is also being gathered on processes in place to achieve the outcomes (process measures). Measurement of progress toward outcomes is also used to determine unmet need, and to measure the impact and effectiveness of services provided. To avoid duplication the key indicators used to measure outcomes and processes are coordinated with HRSA required reports and information available in the SDIS.

Outcome measures for outpatient medical care, case management, psychosocial services, dental care, substance abuse treatment and outreach have been given priority in development. These services have been and will continue to be evaluated using record reviews based on standards of care with the idea that following standards of care contributes to positive outcomes of treatment.

HRSA has made clear its expectations for outcomes to be measured in quality management programs. Mortality and morbidity are the primary outcomes of interest to HRSA. In addition, they are interested in measuring these by examining changes in CD4 counts and Viral Load. In response to these expectations, we are preparing to better specify the outcomes listed above, as well as to add new ones if necessary.

While the outcome measures will focus on HRSA-driven measures, record reviews and guidelines for practice will be incorporated into the measurement and improvement of quality. Agencies will thus be held to a variety of performance measures consistent with good practice in the relevant field.

The Title I Service Delivery Information System (SDIS) and other data sources, such as record reviews and special analyses and reports, will support the measurement of outcomes. All Title I contracted providers of service are connected to the SDIS. Client demographic and service utilization (billing, reporting and monitoring) data are collected in the SDIS.

OUTCOMES 2003
MIAMI-DADE COUNTY RYAN WHITE TITLE I

SYSTEM-WIDE MEASURES

Outcomes	Indicators	Data Elements	Data Sources/Methods
Increase the percentage of the HIV/AIDS population in care	Number of people in care in a year compared with prevalence	Measurement of met and unmet need Measurement of the number not in care People lost to care returned to care	Surveillance data Surveys Unmet need data Cross-program data
Improve health status of the HIV/AIDS population	Improved or maintained CD4 counts, viral loads for clients	Test results needed to calculate changes in CD4 counts, viral loads for individual clients over a specified time	SDIS Cross-program data
Eliminate disparities in care	Gender and race/ethnicity equity in health status measures	CD4, viral load, mortality, utilization of medical care, on ART	Cross-program data

OUTCOMES 2003
MIAMI-DADE COUNTY RYAN WHITE TITLE I

OUTPATIENT MEDICAL CARE

Outcomes	Indicators	Data Elements	Data Sources/Methods
Slowing/prevention of disease progression	Improved or maintained average CD4 counts, viral loads for clients as measured over a specified time period	Test results needed to calculate changes in CD4 counts, viral loads for individual clients over a specified time period	Upload of test data from outpatient medical care providers to SDIS on a quarterly basis
Reduced number or rate of AIDS-related hospitalizations	Change in the rate of AIDS-related hospitalizations over a specified period of time	Number of clients having AIDS-related hospitalizations, and the total number and days of AIDS-related hospitalizations for all clients during the specified time period	Disease Management AIDS algorithm applied to hospital data
Reduced incidence of AIDS-defining opportunistic conditions	Change in frequency of occurrence of AIDS-defining opportunistic conditions among clients over a specified time period	Number of cases of AIDS-defining opportunistic conditions, incidence of preventable conditions (e.g., PCP, MAC) among individual CARE Act clients over a specified period	AIDS Surveillance Data
Increased satisfaction of clients receiving outpatient medical care services	Change in the number of clients who receive outpatient medical care and report a service satisfaction level of good or better	Number and percent of HIV+ clients who receive outpatient medical care and report an overall rating of good or better for outpatient medical care services	Client survey

OUTCOMES 2003
MIAMI-DADE COUNTY RYAN WHITE TITLE I
CASE MANAGEMENT

Outcomes	Indicators	Data Elements	Data Sources/Methods
Increased maintenance of primary care services	Change in the number/percent of case management clients maintaining primary care services (at least one physician visit within the past 6 months) as measured over a specified time period	Number of case management clients maintaining primary care as measured over a specified time period	SDIS service across sites review Quarterly report of follow up with client/provider Future SDIS data report
Timely access to primary care services	Change in the number/percent of new clients entering medical care within a set time frame as measured over a specified period of time	New clients have a medical visit within 2 weeks of initial case management intake	SDIS service across sites review Quarterly report Future SDIS data report Record reviews
Increased number of clients accessing primary health care services.	Change in the number of clients who accessed primary health care programs after a specified time period	Number and percent of HIV + clients who did not have primary health care and accessed primary health care during specified time periods	SDIS data report
Increased satisfaction of clients receiving case management services	Change in the number of clients who receive case management and report a service satisfaction level of good or better	Number and percent of HIV+ clients who receive case management and report an overall rating of good or better for case management services	Client survey

Williams, Stern & Associates

CASE MANAGEMENT PROCESS MEASURES

Process Measure	Data Elements	Data Sources/Methods
Complete bio-psychosocial assessment in record		
Care plan and goals in record, signed and dated by client		
Unduplicated number of clients screened for and enrolled in or formally denied for benefit program (Medicaid (all), Medicare, VA, Food Stamps, WIC, HUD Section 8, and other services in the community		
Each case management client sees the case manager at least every six months		
Information is updated every six months		
Case Manager/client ratio during the contract period.		

SUBSTANCE ABUSE TREATMENT RESIDENTIAL CARE

Outcomes	Indicators	Data Elements	Data Sources/Methods
Improved access to Substance Abuse residential care	Reduction in the number/percent of empty/unfilled beds as measured over a specified time period	Average number of empty beds per SDIS weekly announcement measured over a specified time period	Residential substance abuse reports to SDIS of empty/unfilled beds on a weekly basis
Decreased incidence of return to treatment	Change in the number/percent of returns to treatment for clients completing continuum of care* over a specified period of time	Assessment for prior treatment before continuum of care begun and after continuum of care completed **3 mos. and 6 mos. follow up to determine client remains out of residential treatment and remains drug free	Future quarterly report Future upload/entry into SDIS SDIS across sites service review SDIS data analysis
Increased consistency of medical care	Change in number/percent of clients completing residential treatment and remaining in primary care service as measured over a specified time period	At least one primary care visit within 6 mos. of discharge	Follow up assessment with quarterly report SDIS services across sites review
Improved effectiveness of residential substance abuse treatment as evidenced by length of stay	Change in number/percent of clients completing residential substance abuse treatment	Minimum three (3) months of residential substance abuse completed	Future quarterly report SDIS data
Increase in the number of clients accessing outpatient treatment after completing residential treatment	Change in number/percent of clients entering outpatient substance abuse treatment after completing residential treatment	Clients complete 3 mos. of residential care and within 2 weeks enter outpatient substance abuse treatment	Future quarterly report SDIS data/referrals

OUTCOMES 2003
MIAMI-DADE COUNTY RYAN WHITE TITLE I

SUBSTANCE ABUSE TREATMENT OUTPATIENT CARE

Outcomes	Indicators	Data Elements	Data Sources/Methods
Increased utilization of primary care services	Change in the number/percent of OSAT clients receiving primary care services.	Number of OSAT clients in primary care.	SDIS services across sites review
Decreased incidence of return to treatment	Change in the number/percent of returns to treatment for clients completing outpatient treatment over a specified period of time	Assessment for prior treatment before care is begun and after care is completed	Quarterly report Future upload/entry into SDIS SDIS across sites service review SDIS service data analysis
Improved consistency of medical care	Change in number/percent of clients completing OSAT and remaining in primary care service as measured over a specified time period	At least one primary care visit within 6 mos. of discharge	Follow up assessment with quarterly report SDIS services across sites review
Improved utilization of outpatient substance abuse treatment after completion of residential service	Change in number/percent of clients completing residential treatment and continuing with outpatient substance abuse treatment	Number of clients sequencing from residential care to outpatient care	SDIS data
Improved effectiveness of outpatient substance abuse treatment as evidenced by length of stay	Change in number/percent of clients completing minimal outpatient treatment	Number of clients completing at least 3 mos. of outpatient substance abuse treatment	SDIS data

OUTCOMES 2003
MIAMI-DADE COUNTY RYAN WHITE TITLE I
OUTREACH

Outcome	Indicators	Data Elements	Data Sources/Methods	Benchmark/Target
Increased connection to care	1. Number/percentage of new clients (individuals who have never been enrolled in the Title I system of care) who were connected for the first time to either medical care, case management, or, if necessary, substance abuse treatment.	Of unduplicated client contacts, number and percentage of those contacts who are successfully connected to care per quarter.	SDIS	Providers are required to successfully connect to care no less than 3% of clients contacted.
Increased connection to care	2.Number/percentage of clients lost to followup (those who had not received primary care in the past 6 months) who were reconnected to either medical care, case management, or, if necessary, substance abuse treatment.	Of unduplicated client contacts, number and percentage within a quarter who are successfully reconnected with care.	SDIS	This measurement will provide a baseline for future establishment of benchmarks/targets.
Increased connection to care	3. Increased number of formal written linkage or referral agreements with identified key points of entry and/or with service providers.	Number of formal written linkage agreements, with identified key points of entry and/or service providers, using standard forms with OSBM minimum standards and language,	Administrative reviews	
Increased connection to care	4. Increased number of clients identified through key points of entry	Number of clients identified through key points of entry.	SDIS	

Attachment 3. Glossary of Terms

Quality is the degree to which a service meets or exceeds established professional standards and user expectations. Evaluation of the quality of care should consider 1) the quality of the inputs, 2) the quality of the service delivery process, and 3) the quality of outcomes, in order to continually improve systems of care.

Quality Improvement (QI) or Performance Improvement (PI) refers to activities aimed at improving performance and is an approach to the continuous study and improvement of the processes of providing services to meet the needs of the individual receiving services, and other needs. These terms generally refer to the overriding concepts of continuous quality improvement and total quality management.

Continuous Quality Improvement (CQI)) are generally used to describe the ongoing monitoring, evaluation, and improvement processes. It is a patient/client-driven philosophy and process that focuses on preventing problems and maximizing quality of care. The key components of CQI are:
- Patients/clients and other customers are the first priority
- Quality is achieved through people working in teams
- All work is part of a process, and processes are integrated into systems
- Decisions are based on objective, measured data
- Quality requires continuous improvement.

Total Quality Management (TQM) is a larger concept, encompassing continuous quality improvement activities and the management of systems that foster such activities: communication, education, and commitment of resources.

Quality Assurance (QA) refers to a broad range of evaluation activities aimed at ensuring compliance with *minimum* quality standards.

Performance is the way in which an individual, a group, or an organization carries out or accomplishes its important functions and processes.

Performance measures are quantitative tools that provide an indication of an organization's (or individual's) performance in relation to a specified process or outcome.

Indicators are measures used to determine, over time, an organization's performance on a particular measure or element of care. The indicator may measure a particular function, process or outcome. Examples of indicators include: efficiency, patient satisfaction, effectiveness, timeliness, appropriateness, etc.

Outcomes are results, positive or negative, that may occur during or after a process, activity or intervention. Outcomes can be client-level or system-level.

A **process** is a sequence of tasks to get to an outcome. It is a goal directed interrelated series of actions, events, mechanisms or steps.

A **system** is a group of related processes.

Team refers to a small number of people with complementary skills (cross functional, representing different jobs and perspectives on the issue) who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable. Performance Improvement Teams are an important element of any quality effort. Improvement teams may function within a single agency, if the improvement is to be agency-wide, or may represent several agencies if the improvement is to be system-wide.

Root Cause Analysis is the process of developing permanent solutions to problems by first identifying all the contributing factors and underlying causes of the problem

PDSA – Plan, Do, Study, Act is a widely used framework for testing changes on a small scale before implementing them throughout an organization or group. It is a model for making improvements, and includes root cause analysis, problem identification and clarification, process mapping with flowcharts, analysis of data, development of pilot solutions and evaluation of results of those pilots.